STATE OF DELAWARE

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Part 1: **Name of person whose health information will be disclosed:** *[please print]*

Part 2: **Provider or Entity that has the health information to be released:**

_____ *[please print the name of the entity that has the record to be disclosed; e.g., Dr. Jane Doe, XYZ Insurance Company, ABC Laboratories, etc.]*

Part 3: **Description of the health information to be released:**

ρ Lab results (including drug screening and blood-alcohol test results)
ρ Psychiatric/psychological evaluation
ρ Physical examination results and notes
ρ History, treatment and progress notes
ρ Other: health plan information to include, but not limited to, claims, diagnosis, prognosis, limitations, restrictions, and recommended treatment_____*[describe the health information that may be disclosed]*

Are the records to be released limited to records created during a **specific period of time**: ρ No ρ Yes
If "Yes" indicate specific time period: From *[insert date]* to *[insert date]*

Part 4: **Person or Entity that will receive the health information: Representatives of Statewide Benefits Office and other State Delegates involved in the health plan appeal process.**

Part 5: **Description of the purpose for the release of the health information:**

ρ At the request of the person whose name appears in Box 1
ρ Pre-employment or periodic controlled substance screen or psychoanalysis evaluation
ρ Other *[insert description of the purpose]*: **to assist with coordination of health plan benefits, treatment and coverage associated with the health plan.**

Part 6: **Duration of Authorization:** This Authorization will remain effective *[choose an expiration period or event]*:

Expiration period: ρ 30 days ρ 60 days ρ 90 days ρ 180 days ρ ___ days

Expiration event: *[insert description of an event upon which the Authorization will expire]***: expiration/termination of health plan coverage**

Part 7: **Certification and Acknowledgement:** I certify that I am the person (or the personal representative of the person) designated in Part 1. I agree that my individually identifiable health information described in Part 3, and held by the person or entity listed in Part 2, may be disclosed to the person or entity listed in Part 4 for the purpose(s) designated in Part 5. I understand that the State of Delaware Employee Health Care Plans will not condition treatment, payment, enrollment or eligibility on the provision of this Authorization. I understand that I have the right to revoke this Authorization, in writing, at any time, by sending the revocation to the person or entity who received the Authorization, and that the revocation will be effective except to the extent that the person or entity releasing the information has already taken action in reliance on my Authorization. I understand that, once disclosed, it is possible that the health information may be further disclosed by the recipient and no longer subject to protection under federal privacy rules. ***I have received a copy of my signed Authorization.***

Signature: _____ Date: _____

[If signing as the personal representative of the person in Box 1, print your name and describe your authority to sign for the person]:
Name: _____ Authority: _____

_____

For office use:
ρ Authorization fully completed and signed
ρ Copy of Authorization provided to Individual or Personal Representative